Supreme Court, U.S.
FILED

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No.

IN THE

Supreme Court of the United States

CARLENE GRAHAM, PETITIONER

v.

METROPOLITAN LIFE INSURANCE COMPANY

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. When a defendant pleads ERISA preemption as an affirmative defense to common law bad faith and breach of contract claims, is a plaintiff entitled to have a jury decide whether ERISA applies?

2. During judicial review of an administrator's decision to deny a life insurance claim, does ERISA permit the district court to apply an abuse of discretion standard if the administrator has no discretion to determine eligibility for benefits or to construe the terms of the plan?

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OPINIONS BELOW

The *per curium* opinion of the United States Court of Appeals for the Fifth Circuit, filed on October 22, 2009, although unpublished, is reported at *Graham v. Metro. Life Ins. Co.*, 2009 U.S. App. LEXIS 23337, and is reprinted in the Appendix hereto, pp. 1a-11a.

The Order of the Fifth Circuit denying rehearing *En Banc*, filed December 4, 2009, is unreported and unpublished, but is reprinted in the Appendix hereto, pp. 27a.

The memorandum order of the United States District Court for the Southern District of Mississippi, granting Respondent's Motion for Summary Judgment, filed January 8, 2009, although unpublished, is reported at *Graham v. Metro. Life Ins. Co.*, 2009 U.S. Dist. LEXIS 1555, and is reprinted in the Appendix hereto, pp. 12a-26a.

JURISDICTION

On October 26, 2007, Petitioner brought suit against Respondent in the Circuit Court of Wayne County, Mississippi, alleging Respondent denied her claim for life insurance benefits in bad faith. Petitioner sought extra-contractual and punitive damages based upon Respondent's conduct in denying her life insurance claim. On December 7, 2007, Respondent removed Petitioner's Complaint to the United States District Court for the Southern District of Mississippi asserting federal question jurisdiction based on its allegation that Petitioner's claims were preempted by the Employee Retirement Income Security Act of 1974,

29 U.S.C. § 1001, *et seq.* (ERISA). On December 10, 2007, Petitioner filed an Amended Complaint adding, *inter alia*, an alternative claim under ERISA, 29 U.S.C. § 1132(a)(1)(B).

On January 8, 2009, the Honorable Daniel P. Jordan, III, District Judge for the United States District Court for the Southern District of Mississippi, filed his memorandum order granting Respondent's Motion for Summary Judgment, dismissing Petitioner's claims with prejudice. On January 22, 2008, Petitioner appealed the dismissal of her Amended Complaint to the United States Court of Appeals for the Fifth Circuit.

On October 22, 2009, a panel from the Fifth Circuit issued a *per curium* opinion affirming the District Court. On November 3, 2009, Petitioner timely filed a Petition for Rehearing *En Banc* to the Fifth Circuit. On December 4, 2009, treating Petitioner's Petition for Rehearing *En Banc* as a Petition for Panel Rehearing, the Fifth Circuit panel entered its order denying Petitioner's Petition for Rehearing *En Banc*.

The jurisdiction of this Court to review the Judgment of the Fifth Circuit is invoked under 28 U.S.C. § 1254(1).

RELEVANT PROVISIONS INVOLVED

U.S. Const. Seventh Amend.

> In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no

fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

29 U.S.C. § 1132(a)(1)(B)

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. § 1144(a)

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]. This section shall take effect on January 1, 1975.

STATEMENT

Facts Giving Rise To This Case

This case involves the bad faith refusal to pay a $45,000 life insurance claim Petitioner presented to Respondent in April 2005, after the February 2005,

death of her husband, Robert Graham. Petitioner immediately reported the death of her husband to Respondent. In response. Respondent tendered $8,100 to Petitioner and closed her claim, never providing Petitioner a written explanation for its refusal to pay her the $45,000 to which it was contractually obligated. In response, Petitioner retained counsel and filed her Complaint in the Circuit Court of Wayne County, Mississippi, alleging contractual and extra-contractual damages.

The District Court Proceedings

On December 7, 2007, Respondent removed Petitioner's Complaint to the United States District Court for the Southern District of Mississippi asserting that federal question jurisdiction existed under 28 U.S.C. § 1331 because Petitioner's state law claims were preempted by ERISA. Although Petitioner disputed that the life insurance policy at issue was governed by ERISA, and that her state law claims were thus preempted, the Petitioner amended her Complaint to allege an ERISA claim in the alternative, in case the life insurance policy was indeed governed by ERISA.

Respondent filed a Motion for Summary Judgment seeking a ruling that the life insurance policy for which Petitioner was the beneficiary was governed by ERISA - thus preempting Petitioner's state law claims of bad faith and breach of contract. The Respondent's Motion for Summary Judgment also sought a ruling that the proper standard of judicial review over its denial of Petitioner's claim was abuse of discretion, and that it did not abuse its discretion when

denying Petitioner's life insurance claim. The Petitioner argued in her response that the record established a disputed question of fact regarding whether the life insurance policy was governed by ERISA. The Petitioner further argued that even if the life insurance policy was governed by ERISA, the proper judicial review over Respondent's decision to deny Petitioner's claim is *de novo* because the life insurance policy did not grant Respondent any discretion to interpret the policy or make coverage decisions, but rather expressly vested that discretion in Georgia Pacific - the employer of Petitioner's deceased husband. On January 8, 2009, the district court held: (1) that it - instead of a jury - had the authority to resolve factual disputes regarding whether ERISA preempted Petitioner's state law claims, (2) that ERISA applied to the subject life insurance policy, (3) that Petitioner's state law claims were preempted by ERISA, (4) Respondent's decision to deny Petitioner's claim must be reviewed under an abuse of discretion standard even though the life insurance policy granted no discretion to Respondent, and (5) Respondent did not abuse its discretion in denying Petitioner's claim.

The Appellate Court Proceedings

On January 22, 2009, Petitioner filed her Notice of Appeal to the Fifth Circuit Court of Appeals. On October 22, 2009, a panel from the Fifth Circuit rendered an unpublished, *per curiam* opinion, holding that although the existence of a plan governed by ERISA is a question of fact, "nothing requires this determination be made by a jury; indeed, ERISA

claims do not entitle a plaintiff to a jury."[1] In addition, the Fifth Circuit held that because the resolution of Petitioner's life insurance claim "turned on a factual question", an abuse of discretion standard applies even though the life insurance policy does not give Respondent "discretionary authority to determine eligibility for benefits or to construe terms of the plan." On November 3, 2009, Petitioner filed her Petition for Rehearing *En Banc* with the Fifth Circuit. On December 4, 2009, the panel treated the Petition for Rehearing *En Banc* as a petition for panel rehearing, and denied the Petition without comment.

REASONS FOR GRANTING THE PETITION

I. The Fifth Circuit Panel Improperly Resolved Disputed Questions Of Material Fact When Affirming Summary Judgment On Respondent's ERISA Preemption Defense And Deprived Petitioner Of A Constitutionally Guaranteed Jury Trial

Petitioner alleges in her Amended Complaint that Respondent is liable to her under Mississippi law for breaching its duty to pay her life insurance benefits in bad faith.[2] She alleges contractual and extra-contractual damages caused by Respondent's breach of

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[1]The Fifth Circuit panel's holding in this regard is based on flawed circular logic. ERISA does not act to deprive a plaintiff of a jury trial unless, and until, the defendant meets its burden of proving ERISA applies to the plaintiff's claims. A plaintiff is not deprived of a jury trial based on the *ipse dixit* of a defendant raising the ERISA preemption defense.

[2]In the alternative, Petitioner's Amended Complaint asserts a claim under ERISA to recover the same life insurance proceeds.

contract and its mishandling of her claim.[3] Petitioner's Amended Complaint also demands punitive damages.[4] However, if the Petitioner's right to collect benefits from Respondent under the life insurance policy is regulated by ERISA, then Petitioner's bad faith and breach of contract claims are preempted. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987); *see also* 29 U.S.C. § 1144(a).

Although Respondent's Answer alleged ERISA preemption as an affirmative defense to Petitioner's state law claims, it cannot receive the benefit of that affirmative defense unless it discharges its burden of establishing that the state law claims are preempted. *See Wyeth v. Levine*, 129 S. Ct. 1187, 1196 (2009). When a defendant files a summary judgment motion, it bears the burden of establishing the absence of any material fact, *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986), and the court must view all facts contained in the evidence submitted by the parties, and any inferences that can be drawn therefrom, in the light most favorable to the non-moving party. *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 160 (1970). Summary judgment is only proper if the defendant demonstrates

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[3]Under Mississippi law, the court may award extra-contractual damages if the insurance company fails to pay insurance benefits without an arguable reason. *Universal Life Ins. Co. v. Veasley*, 610 So.2d 290, 295 (Miss. 1992).

[4]Under Mississippi law, punitive damages should be submitted to the jury if the insurer: (1) lacked an arguable reason to deny Plaintiff's claim, and (2) the insurer committed a willful or malicious wrong, or acted with gross and reckless disregard for the insured's rights. *United Am. Ins. Co. v. Merrill*, 978 So.2d 613, 634 (Miss. 2007).

the absence of a genuine issue of material fact. *Celotex*, 477 U.S. at 323.

The Fifth Circuit utilizes a three-prong test to determine whether an employee benefit program is an ERISA plan: "To be an ERISA plan, an arrangement must be (1) a plan, (2) not excluded from ERISA coverage by the safe-harbor provisions established by the Department of Labor, and (3) established or maintained by the employer with the intent to benefit employees." *Shearer v. Southwest Serv. Life Ins. Co.*, 516 F.3d 276, 279 (5th Cir. 2008).

In addition, every circuit is in agreement that a particular insurance policy is governed by ERISA only if, from the surrounding circumstances, a reasonable person can ascertain, *inter alia*, the intended benefits and the procedures for receiving benefits. *Wickman v. Northwestern Nat. Life Ins. Co.*, 908 F.2d 1077, 1082 (1st Cir. 1990); *Gulbert v. Gardner*, 480 F.3d 140, 146 (2d Cir. 2007); *Smith v. The Hartford Ins. Group*, 6 F.3d 131, 136 (3d Cir. 1993); *Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410, 417 (4th Cir. 1993); *Vega v. National Life Ins. Serv., Inc.*, 145 F.3d 673, 676 (5th Cir. 1998); *Kolkowski v. Goodrich Corp.*, 448 F.3d 843, 849 (6th Cir. 2006); *Sanderstrom v. Cultor Food Sci., Inc.*, 214 F. 3d 795, 797 (7th Cir. 2000); *Johnston v. Paul Revere Life Ins. Co.*, 241 F.3d 623, 629 (8th Cir. 2001); *Winterrowd v. American Gen. Annuity Ins. Co.*, 321 F.3d 933, 939 (9th Cir. 2003); *Sipma v. Massachusetts Cas. Ins. Co.*, 256 F.3d 1006, 1012 (10th Cir. 2001); *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982)(*En Banc*); *Kenney v. Roland Parsons Contracting Corp.*, 28 F.3d 1254, 1257 (D.C. Cir. 1994).

When reviewing the district court's decision to grant Respondent's summary judgment on the ERISA preemption defense, the Fifth Circuit panel properly recognized that the existence *vel non* of a ERISA plan is a question of fact. However, it held that there was "no question of material fact that would allow a reasonable trier of fact to determine that an ERISA plan did not exist."[5] This holding was in error because there was a dispute of material fact as to whether a reasonable person could ascertain the intended life insurance benefits, and procedures for receiving those benefits, based on the circumstances. Petitioner offered substantial evidence that a reasonable person could not ascertain the intended benefits or the procedures for receiving those benefits from Respondent. This evidence established disputed fact questions on Respondent's ERISA preemption defense. However, the Fifth Circuit panel completely ignored this evidence.

Respondent, at its corporate deposition, was unable to identify the intended benefits under Petitioner's life insurance policy, or the procedures for receiving benefits. This is exhibited in Respondent's deposition beginning on page 33:

> Q. Okay. Did you tell Carlene Graham who the party was that was making the decision on whether to approve or deny her claim?
>
> A. No, I don't recall that either.

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[5]Interestingly, the panel does not identify what evidence it relied upon to make this decision.

Q. Okay. Did you ever tell Carlene Graham the plan provisions on which you based your decision to tender 8,000 rather than a higher amount for her claim?

MR. KENNA: Object to the form. It assumes facts not in evidence.

Q. You can answer.
A. Read that back, please.

(Question read)
A. I wouldn't recall. There were no claims submitted for higher than $8,000.

Q. Explain to me how Carlene Graham could have submitted a claim for more than $8,000?
A. She wouldn't submit a claim. Georgia Pacific would. If I had gotten anything from her, I would have had to go to them.

Q. With who is the plan - - according to the plan who is Carlene Graham supposed to submit her claim to?
A. SHPS.

Q. Okay.
A. And then SHPS sends it to us - - or used to send it to us.

Q. Okay. Now, for the life portion of the plan, does Georgia Pacific pay MetLife policy premiums for an insurance policy

that covers their employees and beneficiaries of their employees?

A. I would assume so. I'm not involved in that.

Q. So you don't know?

A. No.

Q. Okay. So what does SHIPS - -. When a Claimant submits a claim, they are supposed to submit it to SHPS, correct?

A. Correct.

Q. And then what does SHPS - -. Strike that. MetLife then evaluates the claim?

A. Correct.

Q. Okay. What does SHPS require the Claimant to submit?

MR. KENNA: Object to this being beyond the scope of the Notice, asking her what another party - - another company would require.

Q. What task did Georgia Pacific perform in relation to claims under the submit plan. It's on the Notice. If you don't know, that's fine?

A. I don't know what they require.

Nor did Respondent know what the ERISA mandated appeal procedures were for Petitioner to appeal the Respondent's decision to deny her claim.

Consider the following excerpts beginning on page 15 of Respondent's deposition:

Q. At this point, at the claim's process, was this Carlene Graham's appeal?
A. No. It was just an outgoing phone call.

Q. What is the procedure – let's say an insured like Carlene Graham is dissatisfied with the examiner's decision in a claim –
A. She's not insured.

Q. A beneficiary is dissatisfied with an examiner's decision on a the claim.
A. There was no claim for 48,000.

Q. Let me finish my question. Let's say a beneficiary is dissatisfied with an examiner's decision on her claim, what is her remedy?
A. I guess she would write a letter, if she wanted to.

Q. Can she appeal?
A. There was no denial.

Mr. Brents: He's asking in general, not with respect to this specific claim.

Q. Can she appeal?
A. Then, I guess, I'm not understanding. To me appeal is after someone has had a letter sent to them and they are appealing

our decision. No letter had been sent to her.

Mr. Kenna: Are you talking generally, is that your question or is it specific to this claim?

Q. I'll repeat the question.

Mr. Kenna: I think she answered the question.

Q. My question is very simple. Does Carlene Graham have any kind of remedy or appeal rights?

Mr. Kenna: She answered.

Q. What's your answer to that question?

Mr. Kenna: Read it back.

Q. Does a beneficiary like Carlene Graham generally and specifically have any recourse if they are paid an amount less than they believe they're entitled under the policy?

A. She would have to submit –

Mr. Kenna: Object to the form, in that you are saying a beneficiary like Carlene Graham.

Q. Okay. Did Carlene Graham – my question is, in MetLife policies, does Carlene Graham have any type of recourse if she's dissatisfied with the amount of money she is awarded on her claim?

Mr. Kenna: You can answer.

A. Okay. She can go back to Georgia Pacific and inquire with them why it was only $8,000 or she can submit proof to us so we can go back to Georgia Pacific and see why it was only $8,000. She never submitted any proof to me, so I had nothing to go with.

In addition, the Fifth Circuit panel ignored the Affidavit of Carlene Graham which indicated confusion with the intended benefits and a failure on the Respondent to communicate the procedures for obtaining those benefits:

> 3. Sherry Arrington of Georgia Pacific told me, after my husband died in 2005, that my husband's life insurance policy, for which I was the beneficiary, provided $45,000 in coverage and a few thousand more in interest.
>
> 4. Before filing suit, I called MetLife and Georgia Pacific, and other companies they told me to call, at least 20 times to report my claim and find out why they would only send me $8,100. I told them Sherry Arrington of Georgia Pacific told me after my husband died that the policy insuring my late husband's life provided the

amount of coverage referred to in the paragraph above. My attorney told me MetLife has no record of these phone calls in its files and this is very disappointing to me that MetLife is deceiving the Court to cheat me out of the life insurance proceeds I need, and my husband worked his whole career to accrue, to insure my security after he died. MetLife told me that Sherry Arrington was no longer working for Georgia Pacific any more so it could not call her about my life insurance claim. I called Sherry Arrington thereafter and she told me that she was still employed with Georgia Pacific. I am disappointed to learn from my attorney that MetLife told me this when it had been in contact with Sherry Arrington about my claim and knew she still worked for Georgia Pacific.

5. MetLife told me it was not going to pay me more than $8,100 and there was nothing I could do about it. I asked MetLife why it would not pay what I was entitled to under my husband's life insurance policy, but it refused to tell me. All MetLife kept telling me is that they had no record of my husband's life insurance policy, and that I was not getting any more money. MetLife told me I could hire a lawyer and it still would not have to pay me the insurance money MetLife owed me because it had fancy corporate lawyers. MetLife was very mean and condescending to me on the phone. I was told by Sherry Arrington that the $8,100 dollars I received from MetLife was not even proceeds from a life insurance policy but was a standard payment made to the surviving family upon the death of

any employee, or former employee out on disability leave, like my late husband.

"The Seventh Amendement preserves the right to trial by jury in 'suits at common law'". *Lytle v. Household Mfg., Inc.*, 494 U.S. 545, 550 (1990).[6] When the evidence in this case is viewed in the light most favorable to Petitioner, a fact question exists as to whether Respondent's ERISA preemption defense has merit. As the testimonial evidence establishes, Respondent - the administrator of the life insurance policy - could not ascertain the intended benefits or procedures for receiving benefits, including submitting appeals to the claims administrator. In addition, Petitioner, a reasonable person, could not ascertain the same. This factual dispute regarding ERISA preemption must be resolved by a jury. The district court's failure to submit the disputed facts to a jury violated Petitioner's Seventh Amendment rights and ignored Supreme Court authority that mandates Petitioner receive a trial by jury to resolve the ERISA preemption defense raised by Respondent.[7] The Fifth Circuit panel decision affirming the district court was in error.

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[6]In the Fifth Circuit, "juries must resolve disputed fact issues". *Lytle v. Bexar County Texas*, 560 F.3d 404, 411 (5th Cir. 2009).

[7]This is not to say that if Respondent is successful at trial in convincing a jury to find in its favor on ERISA preemption that Petitioner's alternative ERISA claim would be resolved by a jury. It is the question of whether ERISA preempts Petitioner's claims that must be resolved by a jury under the facts of this case.

II. The Fifth Circuit Panel's Judicial Review of Respondent's Denial of Life Insurance Benefits With An Abuse Of Discretion Standard Is In Conflict With The Holdings Of This Court and All Other Circuits

The language in the life insurance policy at issue in this case, the Georgia Pacific LifeChoices Plan (Plan), vested sole discretion to make benefit determinations and construe the terms of the Plan with Georgia Pacific, granting no discretion to Respondent. The Plan documents expressly state:

Georgia Pacific Corporation is the plan administrator for the LifeChoices Benefits Program. The plan administrator has the exclusive responsibility and complete discretionary authority to control the operation and administration of the plan, with all powers necessary to enable it to properly carry out such responsibility, including but not limited to, the power to construe the terms of the plan, to determine status and eligibility for benefits and to resolve all interpretive, equitable and other questions that shall arise in the operation and administration of this plan.

Clearly, this is a case where Respondent, the administrator of Petitioner's life insurance policy did not have discretionary authority to determine eligibility for benefits or to construe terms of the plan. The United States Supreme Court held in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114 (1989), "that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to

determine eligibility for benefits or to construe the terms of the plan." This holding was reiterated by the United States Supreme Court in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2348 (2008), when it stated, "[p]rinciples of trust law require courts to review a denial of plan benefits under a *de novo* standard unless the plan provides to the contrary."

Notwithstanding these holdings, and as the Fifth Circuit panel held in the case *sub judice*, a Fifth Circuit panel recently held in a published decision that "this Circuit reads *Bruch* as speaking only to questions of law; thus, with or without a discretion clause, a district court rejects an administrator's factual determinations in the course of a benefits review only upon the showing of an abuse of discretion." *Dutka v. AIG Life Ins. Co.*, 573 F.3d 210, 212 (5th Cir. 2009). This Fifth Circuit panel decisions are in conflict with each and every other circuit court considering the same question. *Richards v. Hewlett-Packard Corp.*, 2010 U.S. App. LEXIS 1010 *15 (1st Cir. 2010); *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 622 (2d Cir. 2008); *Schwing v. The Lilly Health Plan*, 562 F.3d 522, 525 (3d Cir. 2009); *Booth v. Wal-Mart Stores, Inc. Assoc. Health & Welfare Plan*, 201 F.3d 335, 340 (4th Cir. 2000); *Shelby County Health Care Corp. v. The Majestic Star Casino, LLC Group Health Benefit Plan*, 581 F.3d 355, 365 (6th Cir. 2009); *Wetzler v. Illinois CPA Soc'y & Found. Ret. Income Plan and Plan Admin. For the Illinois CPA Soc'y & Found. Ret. Income Plan*, 586 F.3d 1053, 1057 (7th Cir. 2009); *Hamilton v. Standard Ins. Co.*, 507 F.3d 1120, 1123 (8th Cir. 2007); *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727, 733 (9th Cir. 2009); *Hancock v. Metropolitan Life Ins. Co.*, 590 F.3d 1141

(10th Cir. 2009); *Capone v. Aetna Life Ins. Co.*, 2010 U.S. App. LEXIS 91 *9 (11th Cir. 2010); *Moore v. Capitalcare, Inc.*, 461 F.3d 1, 11 (D.C. Cir. 2006).

As such, since Respondent was granted no discretion by the life insurance policy or plan documents to determine Petitioner's eligibility for benefits or to construe terms of the Plan, Respondent's decision to deny Petitioner's claim must be reviewed by a district court with a *de novo* standard pursuant to federal law. The Fifth Circuit panel decision holding that an abuse of discretion standard applied in this case was in error, conflicts with this Court's prior holdings, and conflicts with the decisions of every other circuit court. For this reason, the Fifth Circuit must be reversed.

CONCLUSION

Based on the foregoing, this Court should grant this Petition for a Writ of Certiorari. The Fifth Circuit's decision in this case is in conflict with the decisions of this Court and other Circuit Courts. Between January 1, 2008, and January 1, 2010, 17,787 cases have been filed in Federal Court identifying ERISA as the Nature of Suit on the civil cover sheet.[8] The issues raised in this Petition are important; the resolution of which will create more certainty and fairness in the application of a statutory scheme, ERISA, that is viewed by many as a failure in its

[8]This information was derived by entering 791 in the Nature of Suit parameter on PACER and searching all proceedings filed in United States District Courts between January 1, 2008, and January 1, 2010.

congressional purpose to "promote the interests of employees and their beneficiaries in employment benefit plans." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990).

Respectfully submitted

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No. 09-60042 Summary Calendar
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

CARLENE GRAHAM,
Plaintiff-Appellant

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant-Appellee

October 22, 2009, Filed

NOTICE: PLEASE REFER TO FEDERAL RULES OF APPELLATE PROCEDURE RULE 32.1 GOVERNING THE CITATION TO UNPUBLISHED OPINIONS.

Appeal from the United States District Court for the Southern District of Mississippi. USDC No. 4:07-CV-164.

COUNSEL: For CARLENE GRAHAM, Plaintiff - Appellant: Timothy J. Matusheski, Law Offices of Timothy J. Matusheski, Hattiesburg, MS.

For METROPOLITAN LIFE INSURANCE CO, Defendant - Appellee: Alan Harrison Brents, Metropolitan Life Insurance Company, New York, NY; Kenna L. Mansfield, Jr., Wells, Marble & Hurst, Ridgeland, MS.

JUDGES: Before GARZA, DENNIS, and OWEN, Circuit Judges.

OPINION

PER CURIAM: *

Carlene Graham ("Graham") appeals from the district court's grant of summary judgment in Metropolitan Life Insurance Company's ("MetLife") favor, dismissing Graham's ERISA and state law claims which alleged that MetLife did not pay the full amount owed to Graham as the beneficiary of her deceased husband's life insurance policy. Holding that the district court properly determined that the life insurance benefits were provided under an ERISA plan, that there was no abuse of discretion in the plan administrator's determination that Graham was not entitled to an additional $ 45,000, and that Graham did not show she was entitled to attorney's fees, we affirm.

I

Carlene Graham's deceased husband, Robert Graham, was employed by Georgia-Pacific Corporation ("Georgia-Pacific") until his retirement in 2002. Robert Graham had life insurance under Georgia-Pacific's LifeChoices benefits program ("LifeChoices"). Georgia-Pacific initially funded the life and accidental death portion of the LifeChoices program through Aetna, but beginning in 2002 those benefits were funded by MetLife. Under the plan documents, Georgia-Pacific is the plan sponsor, administrator, and record keeper. Sykes HealthPlan Service Bureau Inc. ("SHPS") is Georgia-Pacific's third-party administrator, with responsibility for maintaining eligibility, enrollment, and coverage amount records for participating employees and retirees. Georgia-Pacific designated

MetLife as the benefits claims administrator for the life insurance portion of LifeChoices. MetLife processes and pays claims but relies on Georgia-Pacific and SHPS for verification of eligibility and coverage.

Graham's husband died in February 2005. Graham was named as the beneficiary of her husband's LifeChoices life insurance benefits. She submitted appropriate documentation to collect benefits. Georgia-Pacific and SHPS validated the claim and sent documentation to MetLife that Graham's husband had $ 8,000 in retiree life insurance coverage. MetLife processed a claim payment for $ 8,107.84, representing the $ 8,000 life insurance benefit plus interest. Shortly after receiving the payment, Graham contacted MetLife and stated that a Georgia-Pacific human resources employee, Sherry Arrington ("Arrington"), had notified Graham that her husband was covered for $ 45,000.[1] Arrington maintains that she explained to Graham in writing that "*if* Mr. Graham was approved for waiver of premium that he would be allowed to keep his full amount of $ 48,000." Such a waiver allows active-employee coverage to continue without premium payments if the covered employee becomes disabled. Neither Georgia-Pacific, SHPS, nor MetLife had any record of an approved disability premium waiver. Graham was told that to pursue her claim for additional benefits, she needed to submit proof that her husband had an approved premium waiver for $ 45,000. In November 2005, MetLife denied additional coverage but invited Graham to submit any documentation supporting her claim.

In July 2006, Graham submitted to MetLife an Aetna premium waiver form and attending physician's statement dated February1999. The form had

Arrington's signature on the employer portion of the form showing that Robert Graham had $ 45,000 of coverage through Fort James Corporation and was seeking a premium waiver for disability.[2] Graham offered no proof that the premium waiver form was ever submitted to or approved by Aetna (or anyone else), nor that any coverage, if it existed, transferred from Aetna to MetLife. MetLife provided this documentation to Georgia-Pacific. Georgia-Pacific contacted Aetna but Aetna had no record of a premium waiver for Graham's husband. Georgia-Pacific determined that it could not authorize payment without proof of an approved premium waiver and MetLife closed the claim.

Graham sued in Mississippi state court for breach of contract and bad faith. MetLife removed and Graham then amended her complaint to add claims under ERISA. The district court granted MetLife's motion for summary judgment finding that Georgia-Pacific's LifeChoices program is an ERISA plan that preempted Graham's state law claims, that Graham failed to prove she was entitled to the claimed benefits under 29 U.S.C. § 1132(a)(1)(B), and that she was not entitled to attorney's fees under 29 U.S.C. § 1132(g)(1). *Graham v. Metro. Life Ins. Co.*, No. 4:07CV164 DPJ-JCS, 2009 U.S. Dist. LEXIS 1555, 2009 WL 73802 (S.D. Miss. Jan. 8, 2009).

II

Graham contends that the LifeChoices policy is not an ERISA plan. She relies on excerpts from the deposition of MetLife's corporate deponent who had trouble answering some questions about the claims procedure

relevant to Graham's situation. From this testimony, Graham argues that a fact question existed whether a reasonable person could ascertain the existence of an ERISA plan. Graham also contends that she was entitled to have a jury determine whether the LifeChoices plan qualified as an ERISA plan. We find both contentions without merit.

This court uses a three-prong test to determine whether an employee benefit program is an ERISA plan. *Shearer v. Southwest Serv. Life Ins. Co.*, 516 F.3d 276, 279 (5th Cir. 2008). "To be an ERISA plan, an arrangement must be (1) a plan, (2) not excluded from ERISA coverage by the safe-harbor provisions established by the Department of Labor, and (3) established or maintained by the employer with the intent to benefit employees.[3] *Id.* (citation omitted).

While Graham is correct that the "existence *vel non* of a plan is a question of fact," the appropriate question on summary judgment is whether the "evidence would have allowed a reasonable trier-of-fact to find that an ERISA plan did not exist." *McDonald v. Provident Indem. Life Ins. Co.*, 60 F.3d 234, 235 (5th Cir. 1995). Nothing requires that this determination be made by a jury; indeed, ERISA claims do not entitle a plaintiff to a jury. *Borst v. Chevron Corp.*, 36 F.3d 1308, 1324 (5th Cir. 1994). To determine whether a plan exists, "a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993). A reasonable person could make this determination by reviewing Georgia-Pacific's LifeChoices Summary Plan

Description ("SPD") and the MetLife certificate of insurance for group term life benefits issued to Georgia-Pacific and distributed to its employees. The SPD shows that the intended benefits of the LifeChoices plan include, among other things, life insurance coverage, that participants can designate beneficiaries, and that Georgia-Pacific pays premiums and is the plan sponsor and administrator. The MetLife certificate of insurance, distributed with a memorandum from Georgia-Pacific shows that MetLife processes claims and pays life insurance benefits for plan participants. Thus, there is no question of material fact that would allow a reasonable fact finder to determine that an ERISA plan did not exist. n4

III

Graham contends that even if her state law claims are preempted by ERISA, the evidence nonetheless shows she is entitled to receive $ 45,000 in life insurance benefits under 29 U.S.C. § 1132(a)(1)(B). According to Graham, the 1999 premium waiver form that she produced is proof of her entitlement. Graham also contends that the district court should have reviewed MetLife's denial of the claim *de novo*, rather than for abuse of discretion, because MetLife had no discretion to determine eligibility for benefits.

We review the district court's grant of summary judgment in ERISA cases *de novo*, applying the same standard as the district court. *Wade v. Hewlett-Packard Dev. Co. Short Term Disability Plan*, 493 F.3d 533, 537 (5th Cir. 2009). A district court reviews *de novo* an administrator's denial of benefits under an ERISA plan unless the plan gives the administrator "discretionary

authority to determine eligibility for benefits or to construe the terms of the plan." *Dutka v. AIG Life Ins. Co.*, 573 F.3d 210, 212 (5th Cir. 2009) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989)). "Regardless of an administrator's ultimate authority to determine benefit eligibility, however, factual determinations made by the administrator during the course of a benefits review will be rejected only upon the showing of an abuse of discretion." *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 213 (5th Cir. 1999).

Here, the district court reviewed the denial of benefits under an abuse of discretion standard because it found that the decision to deny the claim turned on the factual question whether Robert Graham obtained a premium waiver for coverage of $ 45,000. *Graham*, 2009 U.S. Dist. LEXIS 1555, 2009 WL 73802 at * 4. We agree that this is a factual question properly reviewed for abuse of discretion.[5]

In applying the abuse of discretion standard to an administrator's factual determinations we analyze whether the administrator acted arbitrarily or capriciously. "If the plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail." *Ellis v. Liberty Life Assurance Co.*, 394 F.3d 262, 273 (5th Cir. 2004). "Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (quotation omitted). Under 29 U.S.C. § 1132(a)(1)(B), Graham bears the initial burden of proving entitlement to ERISA benefits. *See Perdue v. Burger King Corp.*, 7 F.3d 1251, 1254 (5th Cir. 1993).

Georgia-Pacific told Graham that to prove her entitlement to the additional $ 45,000 in benefits, she had to substantiate the existence of an approved premium waiver. Graham does not argue that the terms of the LifeChoices plan did not require such proof. Rather, she contends that the record is sufficient to prove her entitlement to $ 45,000. Graham's only evidence was a February 1999 physician statement and premium waiver form filled out nearly six years before his death by her husband's previous employer, indicating a $ 45,000 life insurance policy under a plan funded by Aetna, not MetLife. Graham offered no evidence that the form was ever submitted to her husband's previous employer or Georgia-Pacific or to any insurer. Nor did she offer any evidence that her husband had received a premium waiver approval. The record shows that Georgia-Pacific, SHPS, and MetLife investigated whether a premium waiver had ever been approved, including by contacting Aetna. Absolutely no evidence exists that any of these entities received Robert Graham's premium waiver form, let alone approved it. We find no abuse of discretion in the determination that Graham failed to show that a valid, approved premium waiver existed entitling her to an additional $ 45,000 of life insurance benefits.

IV

Finally, Graham contends that the district court abused its discretion in denying her request for attorney's fees under 29 U.S.C. § 1132(g)(1). Section 1132(g)(1) provides that a court "in its discretion may allow a reasonable attorney's fee and costs of action to either party." The district court's denial of attorney's fees and costs under ERISA is reviewed on appeal for abuse of

discretion. *Bannistor v. Ullman*, 287 F.3d 394, 408 (5th Cir. 2002). In conducting such review, we consider the following factors:

> (1) the degree of the opposing party's culpability or bad faith; (2) the ability of the opposing party to satisfy an award of attorney's fees; (3) whether an award of attorney's fees would deter other persons who will be acting under similar circumstances; (4) whether the party seeking attorney's fees sought to benefit all participants in an ERISA plan or to resolve a significant legal question under ERISA; and (5) the relative merits of the parties' positions.

Pitts ex rel. Pitts v. Am. Sec. Life Ins. Co., 931 F.2d 351, 358 (5th Cir. 1991). No single factor is determinative, but "together they are the nuclei of concerns" guiding our review. *Bannistor*, 287 F.3d at 409.

The district court denied attorney's fees, stating that Graham's claim was lacking under these factors. We agree and find no abuse of discretion. MetLife did not act in bad faith, an award would have no deterrent effect, Graham admits that her case raises no important questions under ERISA, nor does it seek to benefit all plan participants. At most, the only factor that weighs in favor of attorney's fees is that MetLife presumably has a greater ability to pay them than does Graham.

V

For the foregoing reasons, we AFFIRM the judgment of the district court.

Footnotes

*Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

1There is some dispute in the record whether the amount was $ 45,000 or $ 48,000. Graham initially claimed coverage was for $ 48,000, but her suit alleges $ 45,000 of coverage.

2Graham was previously employed by Fort James Corporation, which was subsumed by Georgia-Pacific in 2000.

3We see no evidence that the second and third prongs of this test were not met, but we decline to discuss them because Graham made no argument before either the district court or this court on this issue, and accordingly, it is waived. *See, e.g., LeMaire v. La. Dep't of Transp. & Dev.*, 480 F.3d 383, 387 (5th Cir. 2007); *Askanase v. Fatjo*, 130 F.3d 657, 668 (5th Cir. 1997).

4Graham's state law claims for breach of contract and bad faith are preempted. Graham makes no argument to the contrary, nor could she. ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to an employee benefit plan." ERISA § 504(a); 29 U.S.C. § 1144(a). "[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remed[ies] conflicts with the clear congressional intent to make the ERISA remed[ies] exclusive and is therefore preempted." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209, 124 S.

Ct. 2488, 159 L. Ed. 2d 312 (2004). The breach of contract claim is preempted because it duplicates the ERISA cause of action for benefits under 29 U.S.C. § 1132(a)(1)(B). *See, e.g., Bank of La. v. Aetna U.S. Healthcare Inc.*, 468 F.3d 237, 242 (5th Cir. 2006). Her bad faith claim is likewise preempted. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987) (finding bad faith claim under Mississippi law not saved from preemption).

5Moreover, both the Georgia-Pacific SPD and the MetLife group life insurance policy issued to Georgia-Pacific include a grant of discretionary authority. The SPD states that Georgia-Pacific has "complete discretionary authority to control the operation and administration of the plan . . . including, but not limited to, the power to construe the terms of the plan, to determine status and eligibility for benefits . . . ." The MetLife policy states, in relevant part: "[T]he Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits."

CIVIL ACTION NO. 4:07CV164 DPJ-JCS

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF
MISSISSIPPI,
EASTERN DIVISION

CARLENE GRAHAM, PLAINTIFF

v.

METROPOLITAN LIFE INSURANCE COMPANY,
DEFENDANT

January 8, 2009, Decided
January 8, 2009, Filed

Daniel P. Jordan III, UNITED STATES DISTRICT JUDGE.

ORDER

This life insurance dispute is before the Court on Defendant Metropolitan Life Insurance Company's motion for summary judgment [41]. Plaintiff Carlene Graham has responded to the motion and filed a motion to strike the affidavit of Thomas F. Presite [45]. The Court, having considered the parties' submissions and applicable law, finds that Defendant's motion should be granted. Plaintiff's motion to strike is denied.

I. Facts and Procedural History

Robert Graham, the late husband of Plaintiff Carlene Graham, was employed by Georgia-Pacific Corporation ("Georgia-Pacific") until his retirement in 2002. [1] As a

retired Georgia-Pacific employee, Robert Graham was provided with life insurance under Georgia-Pacific's LifeChoices benefits program. Beginning in 2002, Georgia-Pacific funded the life and accidental death portion of the program through the purchase of Defendant Metropolitan Life Insurance Corporation's ("MetLife") Group Term Life & Accident Insurance Policy. [2]

According to the policy descriptions, Georgia-Pacific serves as the plan sponsor, administrator, and record keeper. Georgia-Pacific retained Sykes HealthPlan Service Bureau, Inc. ("SHPS") as a third-party administrator to maintain eligibility, enrollment, and coverage amount records for participating employees. Additionally, Georgia-Pacific designated MetLife as the benefits claims administrator for life insurance claims. Because MetLife does not keep records of the coverage amounts for employees, it relies on Georgia-Pacific or SHPS for information regarding the amount of coverage for each employee and then processes the claim.

After Plaintiff's husband died in February 2005, she submitted the appropriate documentation to collect his benefits. In April 2005, MetLife received the documentation necessary to process Plaintiff's claim from SHPS, which included an employer's statement from Georgia-Pacific indicating that Plaintiff's husband had $ 8,000 in life insurance coverage. MetLife processed a claim payment to Plaintiff in May 2005 for $ 8,107.84, representing her husband's benefits plus interest.

In June 2005, Plaintiff contacted MetLife and claimed that Sherry Arrington, a Georgia-Pacific employee, had previously told her that she was entitled to $ 45,000 in benefits. [3] Throughout June, MetLife claims administrators communicated with Arrington and employees at SHPS to determine whether Plaintiff was entitled to the additional funds. According to the administrative record, Arrington informed MetLife that she told Plaintiff in writing that "*if* Mr. Graham was approved for waiver of premium that he would be allowed to keep his full amount of $ 48,000." Defendant's Motion [42] at Exh. 3F (emphasis added). Such a waiver allows continued coverage without premium if the covered employee becomes disabled. Whether such coverage was obtained is the crucial question before the Court.

The record reflects that MetLife's search produced no evidence of premium waiver coverage, and MetLife so informed Plaintiff in writing on November 1, 2005. MetLife did, however, invite Plaintiff to submit additional evidence, and in July 2006 Plaintiff sent MetLife a February 1999 Aetna Group Disability application that appears to have been fully completed. After again searching its records and contacting Georgia-Pacific and Aetna representatives, MetLife found no evidence that the application had been submitted to Aetna, or approved by Aetna, and no proof that any such obligations were assumed by MetLife some three years later. MetLife therefore closed the claim and told Plaintiff over the telephone that "they had no record" to support the claim. Graham Aff. ¶5.

Plaintiff filed the current action in the Circuit Court of Wayne County, Mississippi, asserting state law claims for breach of the insurance contract. MetLife timely removed the action to this Court on the ground that Plaintiff's claims are governed by the Employment Retirement Income Security Act of 1974 (ERISA). Plaintiff subsequently amended her claim to add claims under ERISA's civil suit provisions. Defendant has now moved for summary judgment, arguing that Plaintiff's state law claims are preempted by ERISA and her ERISA claims are meritless.

II. Defendant's Motion for Summary Judgment

A. Summary Judgment Standard

Summary judgment is warranted under Rule 56(c) of the Federal Rules of Civil Procedure when evidence reveals no genuine dispute regarding any material fact and that the moving party is entitled to judgment as a matter of law. The rule "mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a sufficient showing to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986).

The party moving for summary judgment bears the initial responsibility of informing the district court of the basis for its motion and identifying those portions of the record it believes demonstrate the absence of a genuine issue of material fact. *Id.* at 323. The non-moving party must then go beyond the pleadings and designate "specific facts showing that there is a genuine

issue for trial." *Id.* at 324. Conclusory allegations, speculation, unsubstantiated assertions, and legalistic arguments are not an adequate substitute for specific facts showing a genuine issue for trial. *TIG Ins. Co. v. Sedgwick James of Wash.*, 276 F.3d 754, 759 (5th Cir. 2002); *SEC v. Recile*, 10 F.3d 1093, 1097 (5th Cir. 1997); *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075 (5th Cir. 1994) (en banc). In reviewing the evidence, factual controversies are to be resolved in favor of the nonmovant, "but only when . . . both parties have submitted evidence of contradictory facts." *Little*, 37 F.3d at 1075. When such contradictory facts exist, the court may "not make credibility determinations or weigh the evidence." *Reeves v. Sanderson Plumbing Prods. Inc.*, 530 U.S. 133, 150, 120 S. Ct. 2097, 147 L. Ed. 2d 105 (2000).

B. Defendant's Motion [4]

1. Whether the Georgia Pacific Policy is a Plan

Plaintiff contends that her husband's life insurance policy is not an ERISA plan, thus defeating MetLife's preemption arguments. As Defendant notes, Plaintiff actually states in her response that her benefits arise "from a Plan, allegedly administered by Georgia Pacific, not an insurance policy issued by Aetna." Plaintiff's Response at 8. [5] Regardless, the Court will address Plaintiff's claim that the subject plan was not an ERISA plan.

To qualify as an ERISA plan, the arrangement must be "(1) a plan, (2) not excluded from ERISA coverage by the safe-harbor provisions established by the Department of Labor, and (3) established or maintained

by the employer with the intent to benefit employees." *Shearer v. Sw. Serv. Life Ins. Co.* 516 F.3d 276, 279 (5th Cir. 2008). Plaintiff never directly addressed the second and third requirements, focusing instead on the first. [6]

Under the first prong of the analysis, "*a court* must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977 (5th Cir. 1991) (emphasis added) (citations and quotations omitted); *see also Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1991) (citation omitted). Applying this standard, the Fifth Circuit Court of Appeals found an employee's policy was a plan for purposes of ERISA when:

> The benefits provided by the [employer's] plan were described in the [insurer's] policy; the beneficiaries were the [employer's] employees and their dependents; [the employer] paid the entire premiums for coverage of its employees and a portion of the premiums for coverage of the dependents; and the procedures for recovering benefits were explained in the policy manual.

McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 236 (5th Cir. 1995). The Court's focus in making such a determination is "on the employer and its involvement with the plan." *Id.*

Turning to the Georgia-Pacific policy, the Court finds that there was a plan for purposes of ERISA. Other than offering unsupported legalistic arguments of

counsel, Plaintiff's primary contention seems to be that the policy cannot meet ERISA's guidelines because MetLife's 30(b)(6) deponent failed to explain Georgia-Pacific and SHPS's procedures for payment of premiums and claims handling. However, with respect to premiums, the deponent testified that she was "not involved in that," and the MetLife employee's unfamiliarity with Georgia-Pacific's policies does not directly address the Court's inquiry. Plaintiff's Response at 11. In this case, a reasonable person could ascertain from the plan summary that: 1) the benefits are funds payable upon the death of the insured; 2) the intended beneficiaries were Georgia-Pacific employees and their named beneficiaries; 3) the funding of the plan; and 4) benefits would be received by submitting claims to MetLife, Georgia Pacific's claims administrator. [7] Defendant's Motion [42] at Exh. 3; *see McDonald*, 60 F.3d at 236. Accordingly, the life insurance policy was a plan governed by ERISA.

C. State Law Claims

Plaintiff does not dispute that her claims are preempted if her husband's insurance policy is an ERISA plan. Having determined that the life insurance policy is an ERISA plan, Plaintiff's state law claims are preempted by federal law. *See* 29 U.S.C. § 1144(a) (explaining that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"); *Crowell v. Shell Oil Co.*, 541 F.3d 295, 303 (5th Cir. 2008). Defendant's motion for summary judgment is granted as to Plaintiff's state law claims.

D. ERISA Claims

Plaintiff alternatively seeks damages under 29 U.S.C. § 1132(a)(1)(B) for Defendant's refusal to pay $ 45,000 in benefits. Plaintiff bears the burden of proving that she is entitled to the claimed benefits. *Hedgepeth v. Blue Cross and Blue Shield of Mich.*, No. 1:05CV142-SA-SAA, 2008 U.S. Dist. LEXIS 57881, 2008 WL 2954935, at *2 (N.D. Miss. July 29, 2008) (citing *Perdue v. Burger King Corp.*, 7 F.3d 1251, 1254 (5th Cir. 1993)). Defendant contends that Plaintiff has failed to meet her burden.

1. Standard of Review

Unless the terms of the plan grant the administrator discretion to construe the terms of the plan, an administrator's decision to deny benefits is reviewed *de novo*. *See Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 299 (5th Cir. 1999). "Regardless of the administrator's ultimate authority to determine benefit eligibility, however, factual determinations made by the administrator during the course of a benefits review will be rejected only upon the showing of an abuse of discretion." *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 213 (5th Cir. 1999).

The policy behind this rule was well stated in *Pierre v. Connecticut General Life Insurance Co./Life Insurance Co. of North America*,

> The courts simply cannot supplant plan administrators, through de novo review, as resolvers of mundane and routine fact disputes. *See Anderson v. Bessemer City*, 470 U.S. at 574-75, 105 S.Ct. at 1512 ("Duplication of the trial judge's efforts in the court of appeals would very likely contribute only negligibly to the accuracy

> of fact determination at a huge cost in diversion of judicial resources"). Considerations of expediency therefore support deference to factual determinations made in the administration of the plan. Otherwise, federal trials are encouraged in the vast numbers of claims that are filed in the thousands of ERISA plans throughout this country.

932 F.2d 1552, 1559 (5th Cir. 1991). The denial in the present case turned on MetLife's conclusion that Mr. Graham never obtained the disputed coverage. This was a purely factual question that required no interpretation of the terms of the policy. *See Pierre*, 932 F.2d at 1557 (explaining difference between factual questions for which abuse of discretion applies and questions involving interpretation of the plan for which *de novo* review applies absent grant of discretion). Accordingly, the abuse of discretion standard applies.

Under the abuse of discretion standard, "[i]f the plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail." *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 273 (5th Cir. 2004). "Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (quotation omitted). Finally, in conducting this review, the district court is constrained to the evidence in the administrative record. *Vega*, 188 F.3d at 299 (also explaining scope of administrative record).

2. Benefits and Penalties

Plaintiff supports her claim for additional benefits with three documents: 1) the Aetna group disability

premium waiver form filled out by her husband in 1999 when he worked for Fort James; 2) Plaintiff's own affidavit statement that Sherry Arrington, a Georgia-Pacific employee, informed her that she was entitled to $ 45,000 in life insurance benefits plus interest; and 3) a March 24, 2005 letter from SHPS regarding premiums. The Court finds that these documents fail to demonstrate that MetLife abused its discretion.

First, the group disability application merely demonstrates that Plaintiff's husband and his employer filled out an application. There is no proof that the application was properly submitted; that it was approved by Aetna; or that MetLife assumed Aetna's obligations three years later. Significantly, Defendant was not the repository for the relevant documents, and the administrative record clearly demonstrates MetLife's substantial efforts to determine whether Aetna, Georgia-Pacific or SHPS possessed documentation of coverage. Ultimately, Defendant was informed by those entities that no such documentation existed.

Second, Plaintiff claims that Arriginton informed her that the policy "provided $ 45,000 in coverage." Graham Aff. ¶3. However, the record plainly demonstrates that MetLife investigated the statement Plaintiff attributed to Arrington and communicated directly with Arrington for clarification. Arrington provided the following response:

> What Mrs. Graham was told in writing is that *if* Mr. Graham was approved for waiver of premium that he would be allowed to keep his full amount of $ 48,000. She has failed to come up with any

> type of letter from Cigna or Aetna approving the waiver of premium. I do see on file where the paperwork for the waiver was completed but I do not have an approval and Aetna nor Cigna can find a record on Mr. Graham. . . . We are not involved in the waivers other than filling out the employer's part of the paperwork, then we have no way of knowing if they mail it in to the company or not.

Defendant's Motion [42] at Exh. 3F (emphasis added). Arrington's response was consistent with Defendant's other efforts to determine whether there was any record of this coverage. Defendant's conclusion was not an abuse of discretion.

Finally, Plaintiff's response references a March 24, 2005 letter from SHPS regarding coverage. [8] Although the letter is attached to Plaintiff's affidavit, her response offers only the cryptic statement that the letter proves Georgia Pacific continued to pay life insurance premiums to MetLife. What is not clear, however, is whether this letter references the disputed coverage. Moreover, the Court cannot say that Defendant abused its discretion in finding that Mr. Graham was not covered for the additional benefits wher the entities from which conformation would have to come informed MetLife that no coverage existed. Substantial evidence supported MetLife's determination, and the Court finds that it was not arbitrary and capricious. Accordingly, Defendant's motion should be granted. [9]

E. Attorney's Fees

For this same reason, the Court also grants Defendant's motion with respect to Plaintiff's claim for

attorney's fees and costs pursuant 29 U.S.C. § 1132(g)(1). Plaintiff did not respond to this portion of the motion, but the Court finds the claim lacking under the statute and based on the factors found in *Pitts ex. rel. Pitts v. American Security Life Insurance Co.*, 931 F.2d 351, 358 (5th Cir. 1991).

III. Plaintiff's Motion to Strike

Plaintiff has moved the Court to strike the Affidavit of Thomas F. Presite, which MetLife submitted in support of its motion for summary judgment, on the ground that Presite was not identified in MetLife's initial disclosures. Defendant argues that reference to the administrative record in an ERISA matter is sufficient for purposes of Rule 26(a)(1) and, in the alternative, contends that any deficiency in its disclosures was harmless. In rebuttal, Plaintiff asserts that MetLife's failure to name Presite in its initial disclosures prevented her from discovering MetLife's theory of how ERISA applied to her claims.

If a party fails "to identify a witness as required by Rule 26(e) . . . the party is not allowed to use that . . . witness to supply evidence on a motion" unless the failure is harmless. FED. R. CIV. P. 37(c)(1). In considering whether a violation of Rule 26 is harmless, the court considers four factors: (1) the importance of the evidence; (2) the prejudice to the opposing party of allowing the evidence to be used at trial; (3) the possibility of curing such prejudice by granting a continuance; and (4) the explanation, if any, for the party's failure to identify the evidence. FED. R. CIV. P. 26(a), 37(c)(1); *United States v. $ 9,041,598.68*, 163 F.3d 238 (5th Cir. 1998).

The Court finds MetLife's failure to identify Presite in pre-discovery disclosures was harmless. Regardless of the merits of MetLife's explanation, Plaintiff suffered no prejudice because, contrary to Plaintiff's assertion, MetLife specifically identified Presite in its Response to Plaintiff's Interrogatory No. 1, which Defendant served on May 6, 2008. The discovery deadline was September 30, giving Plaintiff more than four months to notice Presite's deposition or request additional discovery. *See Pratt v. Pharmnet*, No. 3:04CV208-D-A, 2006 U.S. Dist. LEXIS 74809, 2006 WL 2943296, at *3 (N.D. Miss. Oct. 13, 2006) (finding failure to list witness harmless when "[i]t [was] undisputed that [witness] was listed by the defendants during discovery").

Furthermore, Plaintiff does not dispute the validity of any of the documents attached to Presite's affidavit. From the Court's perspective, the affidavit served no purpose other than to authenticate the attached documents. *See In re Mahoney*, 368 B.R. 579, 590 (Bankr. W. D. Tex. 2007) ("Regarding the affidavits' function of authenticating the exhibits as business records, the failure of the defendant to disclose the identities of the affiants is harmless."). Accordingly, the Court finds MetLife's failure to name Presite in its initial disclosures harmless. Plaintiff's motion to strike is denied.

IV. Conclusion

For the reasons stated above, Defendant's motion for summary judgment is granted. Plaintiff's motion to strike is denied. A separate judgment will be entered in accordance with Rule 58 of the Federal Rules of Civil Procedure.

SO ORDERED AND ADJUDGED this the 8th day of January, 2009.

/s/ *Daniel P. Jordan III*

UNITED STATES DISTRICT JUDGE

Footnotes

1 Plaintiff initially worked for Fort James Corporation ("Fort James"), which was subsumed by Georgia-Pacific in 2000.

2 The life and accidental benefits plan was previously funded by Aetna.

3 There is some dispute in the record whether the amount was $ 45,000 or $ 48,000. Plaintiff's affidavit claims that it was $ 45,000. *See* Graham Aff. at ¶2. The claims file indicates that she sought $ 48,000. *See generally* Defendant's Motion [42] at Exh. 3F.

4 Plaintiff's memorandum includes certain arguments that are either baseless or conclusory. The Court has considered and rejected all of Plaintiff's arguments, but will more specifically address those discussed herein.

5 Plaintiff also appears to argue that the plan was not in existence during the policy period, and therefore not a plan for purposes of ERISA. If the plan was not in existence, then Plaintiff would have no claim against MetLife, as there is no evidence of any other policy in Mr. Graham's name.

6 For the reasons stated in Defendant's memorandum, the Court nevertheless finds that these requirements have been met.

7 The parties dispute which plan year applies, but each of the plans meet the requirements discussed above.

8 It is not clear whether the letter is part of the administrative record, but for purposes of this opinion, the Court will assume that it was.

9 Plaintiff states in her memorandum that the record contains other "irrefutable proof that she was entitled to at least $ 45,000 in insurance proceeds from MetLife," but she fails to identify that proof. Plaintiff's Response at 14. "The nonmovant is required to identify specific evidence in the record and to articulate the precise manner in which that evidence supports his or her claim." *Fuentes v. Postmaster Gen. of USPS*, 282 Fed. Appx. 296, 2008 WL 64673, at *3 (5th Cir. 2008) (citing *Forsyth v. Barr*, 19 F.3d 1527, 1537 (5th Cir.1994)).

Filed: 12/4/2009
No. 09-60042 Summary Calendar
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

CARLENE GRAHAM,
Plaintiff-Appellant

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant-Appellee

ON PETITION FOR REHEARING EN BANC

PER CURIAM:

Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (Fed. R. App. P. and 5th Cir. R. 35), the Petition for Rehearing En Banc is DENIED.